Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012107	A. BUILDING _____ B. WING _____	12/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODVIEW ASSISTED LIVING	**3320 E STATE BLVD FORT WAYNE, IN 46805**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: December 12, 13, 14, 15, and 16, 2011 Facility number: 012107 Provider number: 012107 AIM number: N/A Survey team: Christine Fodrea, RN, TC Julie Wagoner, RN Tim Long, RN Census bed type: Residential: 89 Total: 89 Census payor type: Other: 89 Total: 89 Woodview Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality review completed 12/20/11 by Jennie Bartelt, RN.	R 000		